NO. OF ATTACHED SHEETS:

| MEDICAL RECORD | REPORT OF MEDICAL HISTORY | DATE OF EXAM |
|---|---|---|

**NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons**

| 1. NAME OF PATIENT *(Last, first, middle)* | | | 2. IDENTIFICATION NUMBER | 3. GRADE |
|---|---|---|---|---|
| 4a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)* | | | 5. EXAMINING FACILITY | |
| 4b. CITY | 4c. STATE | 4d. ZIP CODE | | |

6. PURPOSE OF EXAMINATION

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

| a. PRESENT HEALTH | b. CURRENT MEDICATION | REGULAR OR INTERM. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| c. ALLERGIES *(Include insect bites/stings and common foods)* | | |
| | d. HEIGHT | e. WEIGHT |
| | | |
| 8. PATIENT'S OCCUPATION | 9. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED | |

10. PAST/CURRENT MEDICAL HISTORY

| CHECK EACH ITEM | YES | NO | DON'T KNOW | CHECK EACH ITEM | YES | NO | DON'T KNOW | CHECK EACH ITEM | YES | NO | DON'T KNOW |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Household contact with anyone with tuberculosis | | | | Shortness of breath | | | | Thyroid trouble or goiter | | | |
| | | | | Pain or pressure in chest | | | | Bone, joint or other deformity | | | |
| Tuberculosis or positive TB test | | | | Chronic cough | | | | Loss of finger or toe | | | |
| Blood in sputum or when coughing | | | | Palpitation or pounding heart | | | | Painful or "trick" shoulder or elbow | | | |
| Excessive bleeding after injury or dental work | | | | Heart trouble | | | | Recurrent back pain or any back injury | | | |
| | | | | High or low blood pressure | | | | | | | |
| Suicide attempt or plans | | | | Cramps in your legs | | | | "Trick" or locked knee | | | |
| Sleepwalking | | | | Frequent indigestion | | | | Foot trouble | | | |
| Wear corrective lenses | | | | Stomach, liver or intestinal | | | | Nerve Injury | | | |
| Eye surgery to correct vision | | | | Gall bladder trouble or gallstones | | | | Paralysis *(including infantile)* | | | |
| Lack vision in either eye | | | | | | | | Epilepsy or seizure | | | |
| Wear a hearing aid | | | | Jaundice or hepatitis | | | | Car, train, sea or air sickness | | | |
| Stutter or stammer | | | | Broken bones | | | | Frequent trouble sleeping | | | |
| Wear a brace or back support | | | | Adverse reaction to medication | | | | Depression or excessive worry | | | |
| Scarlet fever | | | | Skin diseases | | | | Loss of memory or amnesia | | | |
| Rheumatic fever | | | | Tumor, growth, cyst, cancer | | | | Nervous trouble of any sort | | | |
| Swollen or painful joints | | | | Hernia | | | | Periods of unconsciousness | | | |
| Frequent or severe headaches | | | | Hemorrhoids or rectal disease | | | | Parent/sibling with diabetes, cancer, stroke or heart disease | | | |
| Dizziness or fainting spells | | | | Frequent or painful urination | | | | | | | |
| Eye trouble | | | | Bed wetting since age 12 | | | | X-ray or other radiation therapy | | | |
| Hearing loss | | | | Kidney stone or blood in urine | | | | Chemotherapy | | | |
| Recurrent ear infections | | | | Sugar or albumin in urine | | | | Asbestos or toxic chemical exposure | | | |
| Chronic or frequent colds | | | | Sexually transmitted diseases | | | | Plate, pin or rod in any bone | | | |
| Severe tooth or gum trouble | | | | Recent gain or loss of weight | | | | Easy fatigability | | | |
| Sinusitis | | | | Eating disorder (anorexia bulimia, etc.) | | | | Been told to cut down or criticized for alcohol use | | | |
| Hay fever or allergic rhinitis | | | | | | | | | | | |
| Head injury | | | | Arthritis, Rheumatism, or Bursitis | | | | Used illegal substances | | | |
| Asthma | | | | | | | | Used tobacco | | | |

11. FEMALES ONLY

| CHECK EACH ITEM | YES | NO | DON'T KNOW | DATE OF LAST MENSTRUAL PERIOD | DATE OF LAST PAP SMEAR | DATE OF LAST MAMMO-GRAM |
|---|---|---|---|---|---|---|
| Treated for a female disorder | | | | | | |
| Change in menstrual pattern | | | | | | |

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

| ITEM | YES | NO | |
|---|---|---|---|
| 12. Have you been refused employment or been unable to hold a job or stay in school because of: | | | |
| a. Sensitivity to chemicals, dust, sunlight, etc. | | | |
| b. Inability to perform certain motions. | | | |
| c. Inability to assume certain positions. | | | |
| d. Other medical reasons *(If yes, give reasons.)* | | | |
| 13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)* | | | |
| 14. Have you ever been denied life insurance? *(If yes, state reason and give details.)* | | | |
| 15. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occurred.)* | | | |
| 16. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)* | | | |
| 17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)* | | | |
| 18. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)* | | | |
| 19. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)* | | | |
| 20. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)* | | | |
| 21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details).* | | | |
| 22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.) | | | |

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

| 24a. TYPED OR PRINTED NAME OF EXAMINEE | 24b. SIGNATURE | 24c. DATE |
|---|---|---|
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**NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."**

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 7 through 11. Physician may develop by interview any additional medical history he deemed important, and record any significant findings here.)*

| 26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | 26b. SIGNATURE | 26c. DATE |
|---|---|---|
| | | |